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UNIVERSITY OF GONDAR AND INSTITUTE OF PUBLIC HEALTH, COLLEGE OF MEDICINE AND HEATLH SCIENCES

COMMUNITY SATISFACTION AND ASSOCIATED FACTORS WITH HEALTH EXTENSION PROGRAM IN BELLOJYGANFOY WOREDA, KEMASHI ZONE, BENISHANGUL GUMUZ REGIONAL STATE, ETHIOPIA

BY: ASHEBER ABESHU MODJO (BSC.)

PRINCIPAL ADVISORS

1. DR MEZGEBU YITAYAL (PHD)
2. MR AMARE TARIKU (MSC, BSC)

A THESIS SUBMITTED TO THE INSTITUTE OF PUBLIC HEALTH, COLLEGE OF MEDICINE AND HEATLH SCIENCES, AND UNIVERSITY OF GONDAR IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF PUBLIC; IN HUMAN RESOURCE MANAGEMENT FOR HEALTH.

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Approved by examining board

Head institute of public health

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Advisors

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Table of content

Abbreviations

AIDS: Acquired Immuno Deficiency Syndrome

AOR: Adjusted Odds Ratio

CI: Confidence Interval

DOTS: Directly Observed Therapies

EPI Info: Epidemiological Information

FMOH: Federal Ministry of Health

HDA: Health Development Army

HEP: Health Extension Program

HEW: Health Extension Worker

HIV: Human Immuno-Deficincye Virus

HP: Health Program

HSDP: Health Sector Developmental Plan

OR: Odds Ratio

PHC: Primary Health Care

SNNP: Southern Nations Nationalities and Peoples

SPSS: Statistical Package for Social Science

STI: Sexually Transmitted Infection

TB: Tuberculosis

UHEP: Urban Health Extension Program

USA: United States of America

USAID: United States Agency for International Development

ß: Beta coefficient

Abstract

Background: The health extension program is an innovative Ethiopian government plan to ensure health equity by creating demand for essential health services through the provision of appropriate health information at a household level in rural and urban parts of Ethiopia. This study is aimed to assess the level of community satisfaction with HEP and the associated factors in; Bellojganfoy Woreda, Kemashi Zone Benishangul Gumuz Regional State, western; Ethiopia.

Objective: The objective of this study was to assess community satisfactions and associated factors with health extension program in Bellojyganfoy Woreda, Kemashi zone, Benishangul Gumuz Regional State, western Ethiopia.

Methods: A community based cross-sectional study, using quantitative and qualitative methods of data collection, in five randomly selected villages were employed. Quantitative data were collected from 555 respondents using a structured questionnaire. SPSS 20.0 Software was used for quantitative data analysis. Descriptive statistics, bivariate and multivariable linear regression analyses were performed. As part of qualitative Focus group discussions were conducted and the data from FGD was transcribed from the tape recorder and the data was analyzed manually by categorizing into different themes and triangulated with the quantitative study

Result: Fifty five point seven percent of the respondents were satisfied with the services provided by the HEP Community Satisfaction with HEP was mostly explained by age of the respondaants, perceived way of communication, perceived relationship, perceived accessibility frequentcy of out reach service, distance and being titled as model family.Perceived way of communication, frequentcy of out reach service, and age were best predictors of satisfaction. The satisfaction score for age group 18-24 respondents was increased by an average of .280 (ß; 95%CI: 0.070 to 0.490) as compared to their 35-44 counterparts. Respondents supplied with regular outreach services satisfaction score of respondents was increased by an average of 34.9% compared to occasional outreach services (ß; 95%CI: 0.236 to 0.463). One-unit increase in respondents' perceived way of communication, the respondents' satisfaction had an average increase by 0.335(ß; 95%CI: 0.252 to 0.417).

Conclusion and recommendation: - The present study showed that interpersonal processes including perceived accessibility, perceived relationship, perceived way of communication, and being awarded as model family significantly influence community satisfaction.Therefore, the health authorities need to strengthen comprehensive and regular observation, monitoring and evaluation on the program and work towards improving the communication skill of HEWs.

Keywords: HEWs, Perceiption, Satisfactions, HEP, Ethiopia

1. Introduction

1.1. Background

To address the health needs of the population, the government of Ethiopia has launched a comprehensive Health Sector Development Plans (HSDP). HSDP is a 20 year plan divided into 3–5 year rolling plans in four consecutive phases. It was developed in response to the prevailing and newly emerging health problems and in recognition of weaknesses in the existing health delivery system. In 2004, Ethiopia launched Health Extension Program (HEP) to expand the national health program to include community based health interventions as a primary component of the HSDP. HEP is “a package of basic and essential promotive, preventive and curative health services targeting households in a community, based on the principle of Primary Health Care (PHC) to improve the families‟ health status with their full participation to further minimize the maternal mortality ratio which is now decreased to 676 deaths per 100,000 live births and Under-five mortality 88 per 1000 live births by 2011which related to poor access to PH (1-4).

The main objectives of HEP are to improve equity and access to essential health interventions at the community level by ensuring ownership and participation of the community, increasing health awareness and skills among community members, improving utilization of PHC services and promoting life styles which are conducive to good health with specific objectives of Reducing morbidity and mortality of children and mothers, Reducing morbidity and mortality from HIV/AIDS, tuberculosis and malaria through development of community skills and knowledge, Preventing diseases caused by malnutrition, poor personal hygiene and contaminated food, Preventing accidents and emergency illnesses, and administering first-aid to the injured and sick, Developing community awareness, knowledge and skills in rural Ethiopia to prevent contamination from common sources including human excreta, animal wastes and pesticides (2).

The philosophy of HEP is that if the right knowledge and skill is transferred to households, they can take responsibility for producing and maintaining their own health. The program was designed with the premises of accelerating the country’s

progress in meeting health related Millennium Development Goals. HEP is composed of four main themes: Disease Prevention and Control, Family Health, Hygiene and Environmental Sanitation and Health Education and Communication (5).

The program is implemented by new health carders called Health Extension Workers (HEWs), who were trained solely for the implementation of the program. Basically, all HEWs are women who completed grade ten and received technical and vocational training for one year (1, 2). Two HEWs were assigned to each kebele (smallest administrative unit) throughout the country. Each kebele has a Health Post (HP) which serves as the operational center for two HEWs.

These new cadres were selected from the communities in which they reside in order to ensure acceptance by community members. They are the first point of contact of the community within the health care delivery system .The main task of HEWs is increasing the knowledge and skill of the community members and households to deal with communicable diseases and be able to access to health services with especial attention to maternal and child health. The fact that maternal and child health package is the milestone in the program; mothers or women are the fundamental unit of interventions for HEP. HEWs are required to spend 75% of their time conducting house –to- house activities to teach and help households and community members to adopt healthy behaviors (2, 6).

Besides providing health education on family health, environmental sanitations and common communicable diseases (TB, malaria and HIV/AIDS), HEWs supervise Directly Observable Treatment-Short Course (DOTS) for TB and antiretroviral treatment for HIV/ AIDS; conduct rapid diagnostic tests for malaria and administer artemether/lumefantrine/; provide family planning and immunization services; attend uncomplicated childbirth and refer patients to nearby health centers. However, HEWs are not allowed to administer antibiotics. HEP educational approach is based on training model families that have acceptance and credibility by the community, as early adopters of desirable health practices to become role models in line with heath extension packages. It was expected that all households would be graduated as models within three years of the implementation of the program(2, 6).

Improving quality in health facilities is a strategy used in developing countries to reduce communicable diseases, which contributes significantly to efforts to attain millennium development goals. Customer satisfaction is an integral service-quality component that

should be monitored closely by health service providers. A customer is satisfied when his/her needs are met adequately when seeking healthcare services (7, 8).

1.2. Statement of the Problem

Joan L. Giese and Joseph A. Cote stated that Literatures contains significant differences in the definition of satisfaction, all the definitions share some common elements like consumer/ customer/ satisfaction is a response (emotional or cognitive), the response pertains to a particular focus (expectations, product, consumption experience, etc.), and the response occurs at a particular time (after consumption, after choice, based on accumulated experience, etc). Customer satisfaction in relationship service delivery shows customer's product- or service-related quality perception must be broadened for three aspects: a competition-related perspective must be added to the service delivered, the customer's level of involvement has to be considered, and the quality construct has to be differentiated on the basis of changes of the customer's internal expectation standard (9, 10).

The major challenges of the health system in Ethiopia included low access to health care services, and low health service utilization. The higher cost associated with expansion of standard health services, and the long time lag between production and deployment of higher-level health professionals such as doctors continued to be the main challenges to address the health problems of rural and marginalized communities with the existing socio-economic situation of the country (1). Community participation, which is critical for the success of program implementation, is recognized as the backbone in the implementation of HEP. Understanding the community in terms of perception on HEP, degree of participation and utilization of services is an important step to improve implementation strategies and approaches in community-based programs(11, 12).

Evidence has shown that at the heart of any health service delivery system is a positive relationship between customer and providers and in fact, it is likely to remain true for the foreseeable future.(7) More importantly, such indispensable aspect of care is clearly fundamental in the future of care where health promotion and health education activities are more important and the primary units of interventions are households. Many of the domestic research on health extension program focused on effect of the

program on different aspects of service delivery, efficiency of the program, implementation and utilization of the program (13-20).

Community satisfaction perspective of the program given little attention in Ethiopia except the attempt done on UHEP community satisfaction and mothers experience and satisfaction on HEP, as limited published evidences able to identify, described the initial community satisfaction on HEP (21, 22). UHEP community satisfaction with HEP may not be representative to all community and even though mothers are center of focus in the program the program needs the participation of husbands too and all representative findings for rural and urban community which shows the level of satisfaction is the gap that is seen on domestic published evidences.

Therefore, it is timely and appropriate to assess rural and urban community satisfaction with HEP as they are the fundamental unit of interventions for HEP packages. Hence, this study primarily intended to assess' community satisfactions with HEP.

1.3. Literature Review

1.2.1. Community Satisfaction

Summary of studies done on customer satisfaction on health intervention and health service providers' interaction with customers in countries like USA, China, and Bangladesh shown the level of satisfaction of the customer can be predicted by background characteristics of respondents such as education, age, income, sex and marital status. Interpersonal relationships, perceived accessibility of services, perceptions of technical competency, time spent ,way of communication and perceived respect and politeness were also have stated as factors that can have association with customer satisfaction (21-32).

The study done on UHEP shows the community satisfaction of the program is 67.4% with the services provided by the in the Hadiya Zone. This study showed that community perception (perceived technical competency, perceived interpersonal relationships, and perceived accessibility) of the service were significantly associated with the satisfaction of the community (22).

The study done in Jimmaa zone revealed that only one-fourth of the households were graduated as model family for being adopters of services given by HEWs. This leaves a huge gap since all households were expected to be trained and graduated during the

first three years of the program implementation and community satisfaction was 69.9% of the respondents with the services provided by rural HEWs which mostly explained by age of the mothers, perceived HEWs' skill to diagnose community problems, perceived respect, involvement of husband in the program and being titled as model family (21).

1.2.2. Factors Associated with Community Satisfaction

1.2.2.1. Socio demographic factors

Studies revealed that socio demographic characteristics of respondents such as education, age, sex and marital status mainly associated with customer satisfaction.

The study in China on residents' satisfaction with community health services after health care system reform shows that the level of community satisfaction mainly associate with education; those with elementary education shown dissatisfaction with the reform than those with higher education which the same on the study in USA (23, 32) but different on the study on Bangladesh and Jimma Ethiopia (25, 26). Regarding to age all literatures reviewed show the level of satisfaction is higher on older age group than younger (21, 24, 26, 32). In relation to sex and marital status limited evidences found to show the association with level satisfaction but there is one research women's satisfaction is higher on OPD service delivery (26) and those who had married have higher level of satisfaction(22, 27).The satisfaction score for single respondents was decreased by an average of 0.314 (95%CI: -0.517 to -0.112) as compared to their married counterparts (27).

1.2.2.2 Relationship with Health Extension worker

A qualitative study done on assessment of health extension workers' relationships with the community and health sector in Ethiopia shows that HEWs' relationships with the community were facilitated by the following: the nature of HEWs' position and role in the community, support from the community (including support regarding referral) and community-driven monitoring and accountability mechanisms (14). Evidences show that providers behavior, empathy, respect and politeness have great influence on level of satisfaction (27-29).

Community satisfaction with the urban health extension service and associated factors in South Ethiopia shows that regarding the relationship of HEWs with the community, 96.7% of respondents had good relationships with HEWs for a one-unit increase in

respondents' perceived interpersonal relationship with HEWs, the level of satisfaction increased by an average 0.506 (95% CIs: 0.216, 0.797) (22).

In Jimma zone 51.7% of respondents, had at least one visit to the HP during the one year prior to the study 75.5%, of the respondents perceived that they had positive interpersonal relationship with HEWs. 83.4%, of them knew HEWs in person perceived respect score would increase the level of satisfaction by an average of 29% (95% CI: 14%–45%, p = 0.001) (21).

1.2.2.3. **Competency of Health Extension worker**

In Welkait, Ethiopia the study done on community perspectives on the Health Service Extension Program indicates Participants were asked to describe their own relationship with their HEW using a 4-point scale. The responses given were "very helpful" (58%), "a bit helpful" (30%) Participants also reported on their impression of HEWs' knowledge, again using a closed response format. They indicated that the HEWs' knowledge was "very good" (58%), "medium" (18%) (12).

Fifty point five percent of respondents in a study in Hadiya zone believed that HEWs were competent to deliver services Accordingly, as respondents perceived technical competency score increased by one unit, the level of satisfaction increased by an average of 0.425 (ß; 95% CIs: 0.16, 0.68) (22). On in Jimma shows perceived HEWs skill to diagnose community problem score will increase the level of satisfaction by 0.17(95% CI: 0.09–0.25, p = 0.001) (21) which show similarty with study on health centers explained by respondents who were indifferent about the technical competence of the provider had an average drop of 0.285 unit in satisfaction score as compared to respondents who agreed (95% CI: -0.467 to -0.104) (27).

1.2.2.4. Time spent

Studies show that the waiting time to get service has significant association on those non elders than elders (24, 30). there is also un evidence which shows the level of satisfaction score will be increased by 0.02(95% CI ;-0.277-0.93) on those visited three times as compared to those visited twice (27).

1.2.2.5. Way of communication

Studies done on United Kingdom and Ethiopia shows non-verbal communication/eye contact/, being told the name of once health problem, and way of dialogue and expectations on way of communication can affect the level of satisfaction (27, 29, 31).

1.2.2.6. Exposure to Health Extension Packages

The study conducted in SNNP shown the respondents used to visit or got advice/ service from UHEPs were 90.4% one year prior to the study period. In addition, for a one-unit increase in respondents' perception on accessibility of service, the respondents' satisfaction had an average increase by 0.752 (ß; 95% CIs: 0.64, 0.86) which shows existence of association (22).

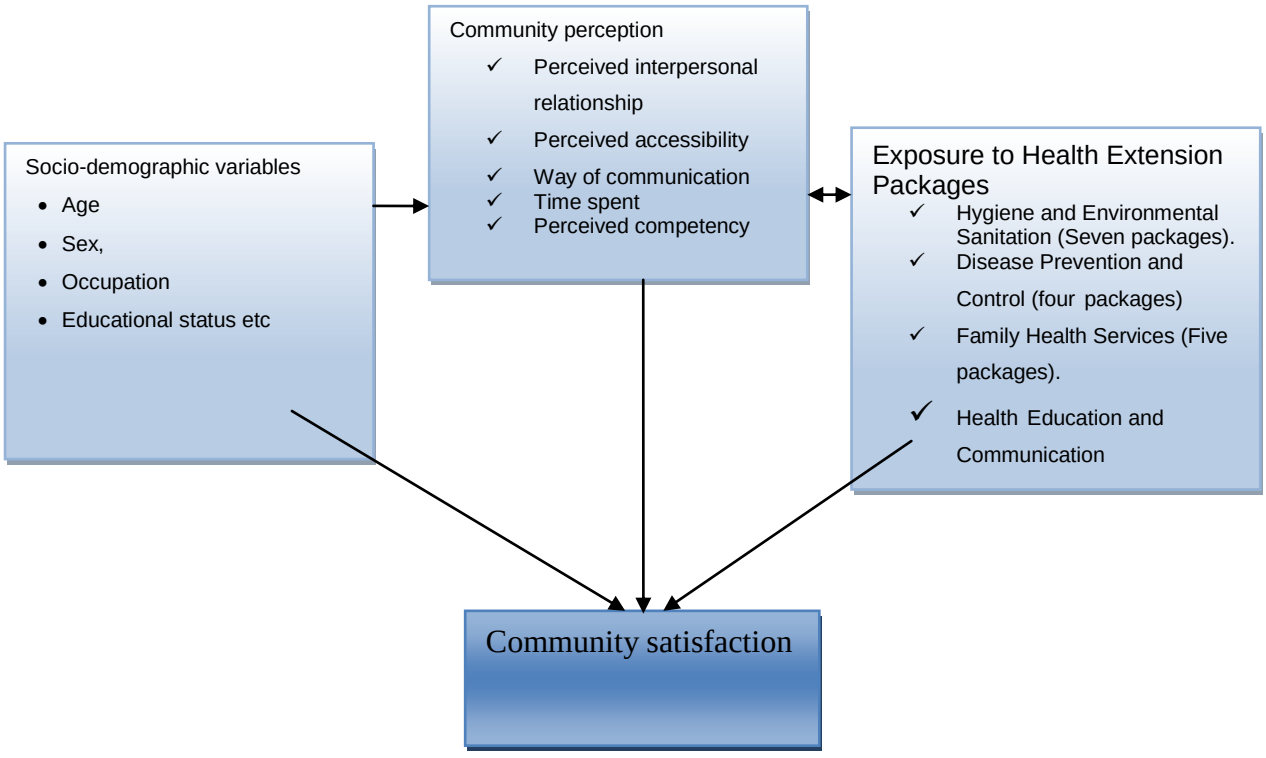
The study in Jimma zone indicated that: - respondents were asked to rate the availability of HEWs at HP. Accordingly, a small percentage of them, i.e., 26.6%, rated regular availability of HEWs at HP. nearly half, 51.2% of the respondents, observed occasional availability of these workers at HP. In relation to this, 90 23.7% of the respondents reported they used to returning home since HP was closed and 78.6% of the respondents had received health information from HEWs. The health information focused on multiple topics. In fact, they had better exposure to information on personal hygiene and environmental sanitation compared to others in HEP packages (21). On this finding health extension workers supplies information on housing hygiene/ condition, personal hygiene and environmental hygiene for more than 90% of study samples which almost to the study SNNP which is 91.8% and being regarded as a model family increases satisfaction by an average of 15.52 (95% CI: 10.79–20.25, p = 0.001) (21, 22).

The study in **SNNP** shows 68.3% of the respondents were well informed about the UHEP but participation in the planning process of the community members is minimal which is less than half 39. 6%. Accordingly, the satisfaction score of respondents' increased by an average of 2.302 as the knowledge score increased by one unit (22).

1.3. Conceptual model

This study focused on community satisfaction with HEP and the services offered to the population by HEWs. Conceptualized the unmet needs of community by revising different literatures, like

- Socio-demographic characteristics,
- Community perception
  - ➢ Perceived technical competency
  - ➢ Perceived interpersonal relation
  - ➢ Perceived accessibility
  - ➢ Perceived way of communication
  - ➢ Perceived time spent
- Exposure to Health Extension Packages that may have an impact on satisfaction.



1.4 Justification of the Study

Health service extension program is a community based approach and the fact that it has been in place in the study on other regions in Ethiopia which is not in case of Benishangul Gumuz region except the attempt done on regular monitoring and evaluation of the program. Progress made and threats faced by the community with the HEP must be under study to come up with base line information to back up district and regional decision makers. Many of the domestic research on health extension program focused on effect of the program on different aspects of service delivery, efficiency of the program, implementation and utilization of the program.

As limited published evidences able to identify, community satisfaction perspective of the program given little attention in Ethiopia except the attempt done on UHEP community satisfaction and mothers experience and satisfaction on HEP described the initial community satisfaction on HEP. UHEP community satisfaction with HEP may not be representative to rural community and even though mothers are center of focus in the program, the program needs the participation of husbands too and all representative findings for rural and urban community which shows the level of satisfaction is the gap that is seen on domestic published evidences. This study will give base line information on level of satisfaction of both rural and urban community which is the gap on domestic researches.

This study will identify factors which will be used to predict community satisfaction level and the associated factors. The study will also give baseline information for further studies that will be conducted on the problem in the study area and other similar settings.

2. Objective

General Objective

- To assess community satisfactions and associated factors with health extension program in Bellojyganfoy Woreda, kemashi zone, Benishangul Gumuz region, western Ethiopia.

Specific Objectives

- To assess the level of community satisfactions with health extension program in Bellojyganfoy Woreda.
- To identify factors associated with community satisfactions with health extension program in Bellojyganfoy Woreda.

3. Methods

3.1. Study Area

This study was conducted at Bellojyganfoy Woreda. Bellojyganfoy Woreda which is found in Benishangul Gumuz Regional State: Kemashi zone. The Woreda is located 196 km from zone town Kemashi and 368km from the regional city Asossa. The total population of Bellojyganfoy Woreda is expected to be 38182 with 8485 households in ten rural Kebeles and one urban Kebele. In the Woreda 12 health posts with 26 rural health extension workers and 2 urban health extension workers and 2 health centers are giving primary health care service in the Woreda. The health extension program started 2000 Ethiopian calendar.

3.2. Study Design and Period

A community based cross-sectional study using mixed methods (i.e. quantitative and qualitative methods) were used. As part of Qualitative study ethnography methodology were used to address 1-5 heads in HDA and model families. The study was conducted from February, 2016 to March, 2016 in Bellojyganfoy Woreda.

3.3. Source and study Population

Source Population

The source population for the study was all population living in rural and urban residence in Bellojyganfoy Woreda.

Study population

The study population was all population with- in the selected kebeles in Bellojyganfoy woreda.

Sampling unit

All households in selected kebeles which are found in Bellojyganfoy woreda were the sampling unit of the study.

Study unit

The study units were selected mothers and head of the households who were in the selected household. As part of qualitative method focus group discussions (FDG) were conducted with 1-5 heads of HAD and model families.

3.4. Inclusion and Exclusion criteria

Inclusion criteria

All households in Bellojyganfoy Woreda within a study period were included in the study. Mothers or head of the households were considered as a respondent.

Exclusion Criteria

Households of Health extension workers were excluded from the study.

Households with less than six month presence in the area were excluded from the study.

3.5. Sample Size and Sampling Technique

Sample size determination

Sample size for estimation of community satisfaction was computed using single population proportion formula using the proportion of community satisfaction.

- $n= Z_{1-\alpha/2}{}^2(P\ (1-P))/w^2 =(1.96)^2 0.5(1-0.5)/0.05^2 =384$

Assuming;

- a 0.05 level of significance with 95%CI, $Z_{1-\alpha/2}$ was 1.96 and
- W=0.05 margin of error,
- 0.5 for unknown population proportion, P value 0.5 due to lack of similar study.

For population less than 10000 using population correction formula

N=n/ (1+n/total households (8485)) Then the minimum sample size required were 367

Adding 10% for incomplete respondent the sample size was 403 and multiplied with 1.5 for the design effect and give the final sample size of 604 samples.

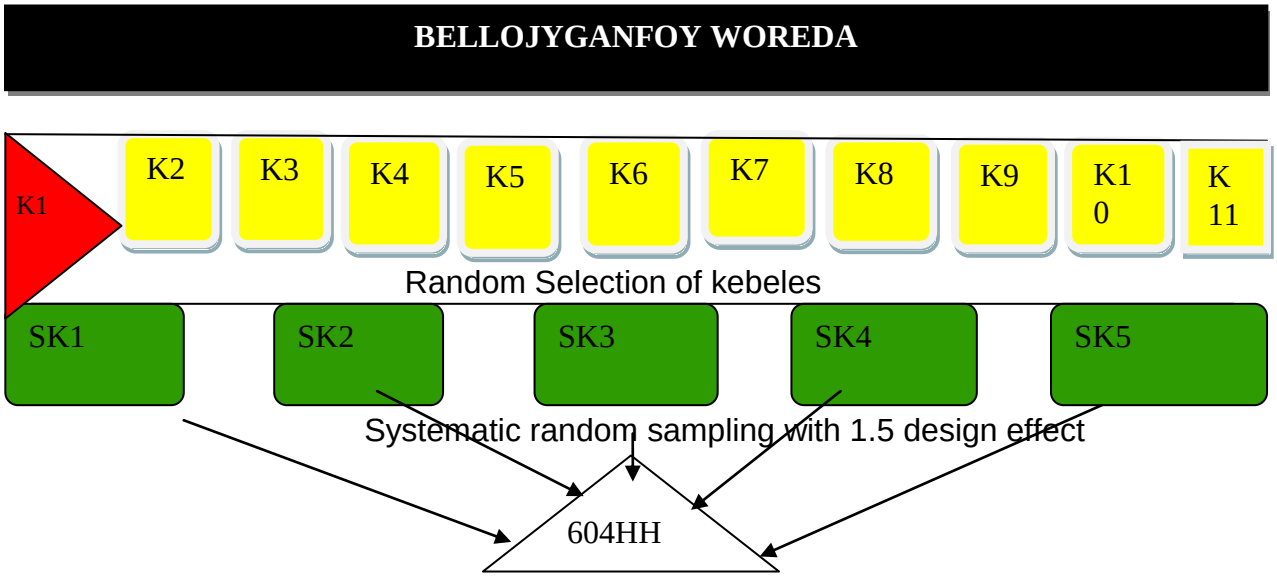
In order to calculate the required sample size using the second approach (power approach) by using EPI software were found to be as mentioned on the table; factors were taken from similar study done in Jimma zone(21), Ethiopia and largest sample size taken from single population proportion formula.

Variable	Possible response	Community Satisfaction		proportion	Sample size
		Satisfied	Unsatisfied		
Recognized as model family	Yes	165	35	P2=(35/175+25)*100=17.5	115
	No**	10	190	P1=(10/20+180)*100=0.5	
Involvement of husband	Yes	62	38	P2=(38/38+62)*100=38	42
	No**	10	90	P1=(10/90+10)*100=10	
Did HEWs visited your home during the last one year	Yes**	80	20	P1=(80/80+20)*100=80	29
	No	59.4	41.6	P2=(41.6/41.6+59.4)*100= 41.6	

** Reference category.

Sampling Technique

A systematic random sampling method was employed to select the households. All 11 kebeles were having the probability to be selected from the Woreda. Furthermore, five kebeles were randomly selected from alphabetically listed kebeles in the Woreda and the first households were selected as an index and using Systematic random sampling with 6 intervals others households were selected until the required sample size was obtained. The study unit was selected by lottery method to have one eligible respond. The sample size includes an additional 10% of households to compensate for possible non-respondents. As part of focus group discussions (FDG) (1-5) heads and model families were selected using reputational-case selection purposeful sampling.



3.6. Variable of the Study

Dependent variable:

- Community satisfaction

Independent variables:

- Socio-demographic variables: age, sex, marital status, educational status, religion, occupation
- Community perception
  - Perceived competency
  - Perceived interpersonal relation
  - Perceived accessibility
  - Perceived way of communication
  - Perceived time spent
- Exposure to Health Extension Packages
  - Hygiene and Environmental Sanitation (Seven packages).
  - Disease Prevention and Control (four packages)
  - Family Health Services (Five packages).
  - Health Education and Communication

3.7. Data Collection, Quality Control and Analysis

Data collection procedure

Data collection format used to extract all the necessary information on the variables of interest was prepared by adapting relevant documents, guidelines and materials (21, 22, 33-36). The format contains four sessions which includes socio-demographic questions, questions related to community exposure, questions related to community relationship with HEWs and questions related to community satisfaction and perception of the respondents of the HEWs session were checked for reliability using Cronbach's alpha. The community satisfaction and perception of the respondents of the HEW part included questions related to the perception of the respondents of the HEWs, which was measured with five different aspects of perception: perceived technical competency of HEWs (ten items with Cronbach's alpha = 0.963), perceived interpersonal relationship with HEWs (five items with Cronbach's alpha = 0. .865), perceived time spent with HEWs (two items with Cronbach's alpha = 0.845), perceived

way of communication (five items with Cronbach's alpha = 0.966) and perceived accessibility of service (five items with Cronbach's alpha = 0.952).

The overall satisfaction of respondents with the health extension program was considered as a dependent variable. Satisfaction of the community was measured using five variables. Each variable was measured on a 5-point Likert scale ranging from (1) (strongly dissatisfied) to (5) (strongly satisfied), yielding a total score of 5–25 with Cronbach's alpha = 0.977.

Five data collectors were selected based on their experience of data collection and cascading FGD and recruited as data collectors and given training on how to extract information from the community and how to cascade FGD. Pre-testing of the data collection format was done and modifications were made. As part of qualitative data collection process, Focus group discussions was conducted with 29 1-5 heads and model families until the idea is saturated through having 6-9 people in one FGD for 1-2hours and each FGD was recorded using recording materials and transcripts were checked for reliability. FGD guide was used to collect the qualitative data.

3.8. Data Quality Control

The data collectors were selected based on their experience, their ability to speak the local language, cascading FDG and previous experience of data collection.

After data collection, the principal investigator reviewed the completeness of the questionnaires at the evening of each data collection date and then immediate correction was made when necessary. The pre-test was done out of the studied Woreda Bello central kebele: sasiga woreda: Oromia region: western Ethiopia before wider field application for 5% of the sample size; and modified according to the findings from the field pretest. The assessment protocol was used as a reference for discussion. Additional support was provided during supervision through regular meetings. The questionnaire was prepared in English, translated into Amaharic, and back translated to English in order to ensure consistency.

3.9. Data Analysis

Review of the completeness of the questionnaires was done at the evening of each data collection date and then immediate correction was made when necessary. Data coding and entry were conducted using EPI info software package and data cleaning was executed with the SPSS 20.0 software package by running frequencies and cross

tabulation. SPSS 20.0 was used for statistical analysis. Descriptive statistics, bi-variate and multivariable regression analyses were performed using linear regeneration model and data were presented by using mean, frequency and percentage and P-value less than 0.05 and 95% confidence intervals and ß coefficient were used to determine an association between independent and dependent variables. The qualitative data was analyzed manually by transcribing from the tape recorder and transcripts were categorized into different themes using frame work analyisis and triangulated with the quantitative study.

3.10. Operational Definition

Households: In this study, households are people residing in rural or smallest administrative unit in kebele.

Satisfaction: the responses, greater than or equal to the mean score are classified as satisfied.

Overall satisfaction level: the responses, greater than or equal to the mean score in aggregated sum response of satisfaction related questions.

3.11. Ethical Consideration

Ethical clearance was obtained from the Institutional Ethical Review Board University of Gondar. Approval to conduct the study wass obtained from the local authorities at the Benishangul gumuz Regional Health Bureau and Bellogjyganfoy woreda and Informed consent was obtained from the study participants and they were assured that the documented personal information would be confidentially kept.

3.12. Dissemination of Result

Timely dissemination of the study findings to the relevant organizations and stakeholders will be primary concern. The plan for dissemination of the project result includes presentation at University of Gondar, and different conferences. The report paper will also be disseminated to Benishangul gumuz Regional Health Bureau, Kemashi zone Health Department, Bellogjyganfoy woreda and other interested governmental and nongovernmental organizations. Publication in scientific journals and online dissemination will be considered

4. Results

Socio-demographic characteristics of the respondents

Five hundred fifty five respondents were interviewed using structured questionnaire, producing response rate of 91.9%. Table (1) presents background characteristics of the respondents. Accordingly, of the total respondents, 93.9% were females and (94.8%) of them were married and 35.0% were aged between 34 and 44 years. In terms of religion, 298 (53.7%) of the respondents were Protestant. Nearly third fourth, 395(71.2%) of the respondents, were Housewife s and the dominant ethnic group was Gumuz, 342 (61.6%). Regarding educational status, 63.2% of the respondents were not educated 27.9% of them had attended primary school.

Exposure to HEP packages

Table (2) presents respondents' exposure to HEP packages. Accordingly, 487 (87.7%) of the respondents had received health information from HEWs. The health information focused on multiple topics. In fact, they had better exposure to information on proper and safe solid and liquid waste management, proper and safe excreta disposals and malaria prevention and control compared to others in HEP packages, which is, 87.3%, 87% and 86.9% respectively. On the other hand, the proportions of respondents who were exposed to Adolescent reproductive health and First AID package (e.g. Tuberculosis) appeared to be lower. A FGD discussion also shows similar pattern. Most discussants frequently mentioned that they received information on how to keep personal hygiene, keeping rooms and surrounding clean, how to use toilet and utilization of insectside treated bed net than other issues. For instance, a participant said: *"after HEWs employed for our kebele we get a lot of advice to improve our personal hygiene, home hygiene and keeping our environment clean so we improve our family health"*.

Table 1 Socio-demographic characteristics of the respondents Belojyganfoy, Ethiopia, March 2016

Socio-Demography	Frequency (%)
Age	
18-24	27(4.9)
25-34	148(26.7)
35-44	194(35.0)
45-54	116(20.9)
55+	70(12.6)
Sex	
Male	34(6.1)
Female	521(93.9)
Ethnicity	
Gumuz	342(61.6)
Berta	27(4.9)
Oromo	78(14.1)
Amahara	93(16.8)
Tigre	15(2.7)
Level of education	
Not educated	351(63.2)
Grade 1-4	79(14.2)
Grade 5-8	76(13.7)
Grade 9-10/12	32(5.8)
Graduated	17(3.1)
Familysize	
2-5	298(53.7)
6-10	249(44.9)
>10	8(1.4)
Occupation	
Housewife	395(71.2)
Private employee	129(23.2)
Government employee	30(5.4)
NGO	1(0.2)
Marital status	
Married	526(94.8)
Single	9(1.6)
Widowed	9(1.6)
Divorced	5(0.9)
Separated	6(1.1)
Wife/husband marital status	
Mono gamy	515(92.8)
Poly gamy	40(7.2)
Religion	
Orthodox	209(37.7)
Muslim	44(7.9)
Protestant	298(53.7)
Catholic	4(0.7)

Table 2 Respondents' exposure to HEP packages, Belojyganfoy, Ethiopia, March 2016

Health extension package	Frequency	Percent
Proper and safe excreta disposals	483	87
Proper and safe solid and liquid waste management	485	87.3
Water supply safety measures	448	80.7
Food hygiene and safety measures	431	77.7
Healthy home environment	461	83.1
Arthropods and rodent control	360	64.9
Personal hygiene	480	86.5
HIV AIDS prevention and control	476	85.8
TB prevention and control	440	79.3
Malaria prevention and control	482	86.9
First AID	301	54.2
Maternal and child health	411	74.1
Family planning	439	79.1
Immunization	479	86.3
Adolescent reproductive health	310	55.9
Nutrition	382	68.8

Relationship with Health Extension worker

Two hundred sixty seven (48.1%) of the respondents were awarded the title of model families as adopters of services given by HEWs. 543 (97.8%), visited to the HP during the one year prior to the survey.Three hundred sixteen (56.9%) of the respondents visited to the HP at least four times. Of those respondents who visited the HP, the majority, 222(40.0%), reported having 1-30 minute travel to get service they wanted. Respondents were asked to rate the availability of HEWs at HP. Accordingly, a small percentage of them, i.e., 66(11.9%), rated rare availability of HEWs at HP. nearly half, 313(56.4%) of the respondents, observed occasional availability of these workers at HP. In relation to this, 506 (91.2%) of the respondents reported they used to returning home since HP was closed. In the qualitative study, also it was hardly possible to get HEWs at HP for the majority of the participants as ascertained. According to them, as a result, people suffer to get service delivered at HP. 548(98.7%) of the respondents

stated HEWs were visiting their home during the last one year prior to the survey. Only 383(69.0%) of the respondents responded that their family participated in the discussion about HEP during home visit by HEWs. Respondents were asked to rate how frequently HEWs conducted outreach services, the majority, 307(54.4%), of the respondents rated that the visit as 'intermittent'. Despite the higher time devoted for home visit, FGDs participants' opinions also supported this finding except in some of the districts. For instance, a discussant said. "*HEWs does not have regular home visiting program this unprogrammed home visit left us to not apply the advice delivered and regular monitoring is mandatory for applicability of the packages*". The majority of the respondents, 509 (91.7%), supported the involvement of female workers in HEP However, 429 (77.3%) agreed that two HEWs are adequate per Kebele to carry out health extension services. Added to this, nearly half, i.e., 205(36.9%), of the respondents did not agree with the range of services being provided by HEWs. The study revealed that more than three-fourth, 438(78.9%), of the respondents perceived that they had positive interpersonal relationship with HEWs. Added to this most, 487(87.7%), received health related information or advice from HEWs. 470(84.7%) Prefer to receive health related information or advice from HEWs. 278(50.1%) of respondents doesn't Participated in planning and implementation of HEP.

Overall Community Satisfaction (Descriptive statistics for satisfaction)

The mean score of overall community satisfaction with the HEP was 54.9766(SD ±23.9359; possible range of responses 20–100). The majority (55.7%) of the respondents had an overall satisfaction score above or equal to the mean value. Thus, 55.7% of the respondents were satisfied with the services provided by the HEP in the Belojyganfoy Woreda.

Descriptive statistics for emerged factors on perception of the Community on Satisfaction Sub-Scales

The mean score of the scales was computed for perceived accessibility, perceived competency, perceived interpersonal relationship with HEWs, perceived time spent, and perceived way of communication in five key aspects of satisfaction.. Each scale was subjected to factor analysis to investigate the underlying components and to reduce the number of items based on eigenvalue by principal component analysis. Factors with eigenvalue less than one were discarded and only those with eigenvalue

greater than one were considered in subsequent analysis. Factor score was computed for the item identified to represent the satisfaction scale by varimax rotation method. Using this regression factor score, multivariable linear regression analysis was performed and the effect of independent variables on the regression factor score of the dependent variable was quantified. The mean score was calculated for each sub-scale of satisfaction after which they were summed and converted into percent values for comparison. The highest mean score was found for perceived time spent of HEWs at health service delivery (60.0901±23.50572) (Table 4).

Table 3 Relationship with Health Extension worker of the respondents Belojyganfoy, Ethiopia, March 2016

Variable	Response category	Frequency (%)
Recognized as model family		
	Yes	267(48.1)
	No	2 88(51.9)
Ever visited HP during the last one year		
	Yes	543(97.8)
	No	12(2.2)
Frequency of visit during the last one year		
	< three times	239(43.1)
	= > four times	316(56.9)
How long you will take to reach at HP on foot (in minutes)	1-30	222(40.0)
	31-60	115(20.7)
	>61	218(39.3)
Availability of HEWs on job at health post	Always	176(31.7)
	Occasional	313(56.4)
	Rarely	66(11.9)
Returned home due to HP being closed	Yes	506(91.2)
	No	49(8.8)
HEWs visit your home during the last one year	Yes	548(98.7)
	No	7(1.3)
Frequency of outreach services	Rarely	84(15.1)
	intermittent	307(54.4)
	Most of the time	169(30.5)
All members of your family involve on HEP	Yes	383(69.0)
	No	172(31.0)
HEWs are adequate per kebele	Yes	429(77.3)
	No	126(22.7)
Support the involvement of female workers in HEP	Yes	509(91.7)
	No	46(8.3)
Service provided by HEWs are enough	No	205(36.9)
	Yes	350(63.1)
Ever received health information from HEWs	Yes	487(87.7)
	No	68(12.3)
Positive interpersonal relationship with HEWs	Yes	438(78.9)
	No	177(21.1)
Participated in planning and implementation of HEP	Yes	277(49.9)
	No	278(50.1)
Prefer to receive health related information or advice from HEWs	Yes	470(84.7)
	No	85(15.3)

Predictors of satisfaction with HEP

Table (5) contains regression estimates for variables significantly associated with satisfaction as identified through bivariate analysis and finaly fitted to the model constructed using stepwise linear regression to identify independent predictors of satisfaction. This model explained 71.9% of the variation in community satisfaction.Community Satisfaction with HEP was mostly explained by age of the respondants, perceived way of communication, perceived relationship, perceived accessibility frequency of out reach service, distance and being titled as model family.Perceived way of communication, frequentcy of out reach service, and age were best predictors of satisfaction. The satisfaction score for age group 18-24 respondents was increased by an average of .280 (ß; 95%CI: 0.070 to 0.490) as compared to their 35-44 counterparts. Frequency of outreach services and traviling time in minutes to health post appeared to be statistically associated with satisfaction factor score. The satisfaction score for 31-60 traviling time in minutes of respondents was increased by an average of 0.189(ß; 95%CI: 0.068 to 0.310) as compared to their 1-30 (in minutes), counterparts. with those respondents supplied regular outreach services satisfaction score of respondents was increased by an average of 34.9% compared to occasional outreach services (ß; 95%CI: 0.236 to 0.463).

Analysis with multivariable linear regression showed that only perceived accessibility perceived way of communication, perceived interpersonal relationships, and perceived accessibility of the service were significantly predictors of the satisfaction of the community. Accordingly, for a one-unit increase in respondents' perceived way of communication, the respondents' satisfaction had an average increase by 0.335(ß; 95%CIs: 0.252 to 0.417). Similarly, for a one-unit increase in respondents' perceived interpersonal relationship with HEWs, the level of satisfaction increased by an average .277(ß; 95%CIs: 0.194 to 0.360). In addition, for a one-unit increase in respondents' perception on accessibility of service, the respondents' satisfaction had an average increase by 0.143(ß; 95% CIs: 0.061 to 0.226) and (Table 5).

Table 4 Mean score for emerged factors, in Belojyganfoy, Ethiopia, March 2016 Ethiopia

Variables	No of items	Mean	SD	Range of possible score
perceived competence	10	52.0360	±19.69145	20-100
perceived time spent	2	60.0901	±23.50572	20-100
perceived accessibility	5	55.8126	±23.46133	20-100
perceived relationship	5	47.1568	±17.21416	20-100
perceived way of communication	5	55.0126	±21.95971	20-100

Table 5 Regression estimates of the predictors of community satisfaction among respondents in Belojyganfoy, Ethiopia, March 2016 Ethiopia

Explanatory variable	Unstandardized ß	P-value	95% CI for ß
Perceived way of communication	.335	.000	.252 , .417
Perceived relationship	.277	.000	.194 , .360
Frequently do HEWs conduct out reach(Mostly /intermittent **)	.349	.000	.236, .463
Perceived accessibility	.143	.002	.061, .226
Time taken to reach at HP in minutes (>61/1-30**)	.189	.001	.068 , .310
Age(25-34/35-44**)	.154	.003	.051, .256
Age(18-24/35-44**)	.280	.009	.070, .490
Recognized as model family(yes/ No**)	.127	.018	.022, .232

****References category (categories with highest frequency taken as reference categories)**

5. Discussion

This study aimed to assess community satisfaction with the HEP which is characterized by limited prior study in program area. HEP is “a package of basic and essential promotive, preventive and curative health services targeting households in a community, based on the principle of Primary Health Care (PHC) to improve the families‟ health status with their full participation(1, 2, 5, 6, 19) . The study revealed that the mean score of overall community satisfaction with the services provided by the HEP was 54.98(SD ±23.94. Thus, 55.7% of the respondents were satisfied with these services provided by the HEP. This figure is lower than as compared to the study

conducted in the Jimma Zone in a rural community, and in South Ethiopia on urban communities which is 69.6%% and 67.4%% respectfully of the respondents were satisfied with the services provided by HEWs (21, 22). This might be due to the difference in the study area or the status of HEWs and the time when the program is launched in the region. The rural health extension program was initiated far behind five years after program was initiated at national level (6).

More than third-fourth of the respondents received health information on some health extension packages during one year before the survey. This finding is found to be better compared to earlier reports (21, 22).. Better exposures to information observed for hygiene and environmental sanitation packages. However, consistent with some earlier reports (17, 19, 22), community exposure to Maternal and child health, Nutrition and Adolescent reproductive health package was lower. This might be due to the higher attention laid on the outreach services as program expectations.

The study showed that only 48.1 % of the households were awarded as model family. Graduation of model families is far behind the expectation as previous studies also documented (2, 6, 11, 14, 21, 22). travel time between households and competing demands for family members' time for farming activities,Multitasking of HEWs, degree of participation and utilization of services by the community, less involvement of community volunteers in the program, less acceptance of HEWs, lack of commitment from HEWs, availability of client friendly health service infrastructure; and strength of health systems, perceived risk that Health Extension Workers (HEWs) may not be equipped with the necessary skills, Career advancement and competence limited comprehensive and supportive supervision, shortage of supplies, poor transportation and communication facilities are reasons for low progress on graduating model families (2, 11, 14, 16).

The current finding is consistent with the expectations of the program as more than half of the respondents stated that HEWs were infrequently available at HPs. On the other hand, inconsistent with the study, most respondents did not agree with the claim that HEWs were spending most of their time on conducting outreach activities. The qualitative finding also revealed similar experiences: most discussants argued that HEWs spent most of their time on their own private work rather than spending their time on service delivery this is majorlly seen because of lack of monitoring from there heads.

The majority of the participants support that female workers are preferred for service delivery of the program. It is believed that active involvement of both females and males is a necessary condition for HEP success. The involvement of female HEWs in the program was preferred on the grounds of degree of closeness, easier disclosure of personal problems and cultural norms. This might reflect the fact that most participants tend to have better relationship with HEWs. similarly, the extent of reported relationship was slightly higher compared to an earlier report (21).

More than 87% of the respondents had received advice or services from health extension professionals in the year prior to the study. This is lower than that of study conducted in the health extension program in SNNP region and greater than study conducted in jimma (21, 22). The differences may be attributable to socio-cultural variations, in that information is more readily available to urban residents than rural residents.

The objectives of HEP can be achieved if the community is involved in planning and implementing the programs, and therefore; have a voice about their own health and health care (2, 6, 29). In the present study, however, 50.1% of the respondents did not participate in the planning and implementation of the program. This finding is inconsistent with study conducted in the urban health extension program in SNNP region (22). This may be because irregularity in schedule of meetings, skills of HEWs to engage with community could be possible reasons.

This study also showed that Age of respondents, distance , Frequency of outreach services , Service provided by HEWs ,perceived accessibility, perceived relationship and perceived way of communication were independent predictors of community satisfaction ($P < 0.05$). Other studies conducted in rural and urban health extension program and PHC services showed that perceived way of communication, perceived respect, and perceived technical skill and competency of HEWs and perceived accessibility were predictors of satisfaction (19, 21, 22). Even though it is difficult to compare the perception of urban respondents with that of rural respondants, there are some factors that are common to both settings, such as perceived way of communication and perceived accessibility of health care providers.

6. Conclusion

Both the quantitative and qualitative components of the present study have clearly shown that the majority of the respondents were satisfied with the services provided by the HEP.The respondents' preferranse to females to deliver HEP services, and the involvement of all members of respondants family on HEP gets higher recognition. Inaddition, respondents have favorable exposure on HEP packages. On the other hand, age of respondents, distance, and frequency of outreach services, awarded as model family, perceived accessibility, perceived relationship and perceived way of communication, were identified as independent predictors of community satisfaction. This study is considered the satisfaction of the community with HEP services. Further study is needed considering the aspect of health extention workers, the actual utilization of the service by the community and the quality of the service delivered.

7. Limitations of the study

This study has some limitations which include; the study was focused on household's side of view we did not study the reflection of HEWs and other stakeholders. In addition, the small geographic area covered on the study also affects generalization of the finding. The social desirability bias might result deu to administrated questioner. The seasonal variation on satisfaction may not reflect the actual situation and needs follow-up study.

8. RECOMMENDATIONS

For regional health biro and woreda health office

- Strengthen programmed observation and evaluation of each components of health extension programs
- Apply frequent observation of each working places and practice of health HEWs to give immediate corrections for problems and to strengthen good situations/activities.
- Work on skill of health professionals to strengthen monitoring and evaluation of the program
- Give training and orientation for new health care workers.
- Give training towards improving the communication skill of HEWs

For all health professionals

- Apply properly and regular monitoring and evaluation of the program give feedbacks

For researchers

- Give priority attention for the program to empower the program to inhence the potential for community health problem solving.

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Annex

Annex 1- Information Sheet

COMMUNITY SATISFACTIONS AND ASSOCIATED FACTORS WITH HEALTH EXTENSION PROGRAM IN BELLOJYGANFOY WOREDA, KEMASHI ZONE, BENISHANGUL GUMUZ REGION, ETHIOPIA

Information Sheet and Consent Form

Assessment/ Study Group: _____

UNIVERSITY OF GONDAR

Name of the organization: University of Gondar

Name of the Sponsor: ----

Name of the Principal Investigators: Asheber Abeshu

Information Sheet and Consent Form is prepared for community that studies the community satisfaction with HEP and its associated factors at Bellojyganfoy Woreda, Kemashi zone, Benishangul Gumuz regional State western, Ethiopia

Introduction: This information sheet and consent form is prepared by the study team whose main aim is to study community satisfaction with HEP and its associated factors at Bellojyganfoy Woreda. I am working for a thesis research project conducted in collaboration with Gondar University. I am asking your response about level satisfaction, perception and experiences with HEP at Bellojyganfoy Woreda.

Purpose: The purpose of this study is to assess mothers' satisfaction after delivery and its associated factors on delivery services at at Bellojyganfoy Woreda. This is an interview that targets community who will live at Bellojyganfoy Woreda. Your responses are very important, and will be helpful in planning for the necessary support towards improving the satisfaction of community on HEP services.

Procedure: In order to assess community' satisfaction with HEP and its associated factors at at Bellojyganfoy Woreda, we invite you to take part in our project. If you are willing to participate in our project, you need to understand and sign the consent form. Then, you will be asked to give your response by the data collectors. For this questionnaire based study, participants are community who will live at Bellojyganfoy

Woreda All responses given by the participants, and the results obtained will be kept anonymous and confidential using coding system whereby no one will have access to your responses.

Risk and/or Discomfort: By participating in this research project you may feel that it has some discomfort specially on wasting your time but this may not be too much comparing its potential benefits it contributes to the overall understanding of factors affecting the satisfaction of community for effectively providing delivery health extention services to the community. There is no risk in participating in this research project.

Benefits: If you participate in this research project, you may not get direct benefit but your participation is likely to help us in assessing community' satisfaction with HEP and its associated factors on delivery services at Bellojyganfoy Woreda, Kemashi zone, Benishangul Gumuz regional State western, Ethiopia. It will also give an insight about the community satisfaction about HEP services based on the findings of the study for improving the health status of the community.

Incentives: You will not be provided any incentives to take part in this project.

Confidentiality and Anonymity: The information that we will collect from this research project will be kept confidential. Information about you that will be collected from the study will be stored in a file, which will not have your name on it, but a code number assigned to it. Which number belongs to which name will be kept under lock and key, and it will not be revealed to anyone except the principal investigator.

Right to Refuse or Withdraw: You have the full right to refuse from participating in this research (you can choose not to respond some or all of the questions) if you do not wish to participate; and this will not affect your health services you get at from any health facilities. You have also the full right to withdraw from this study at any time you wish to, without losing any of your rights as a beneficiary of health services.

Persons to contact: If you have any question you can contact any of the following individuals and you may ask at any time you want.

1. **Name of Principal Investigator:** Asheber Abeshu University of Gondar
   Tel: +251920291548: E-mail: hiasher12@gmail.com
2. **Name of Supervisor:** DR Mezgebu Yitayal University of Gondar
   Tel: +251-947-057683: E-mail: _____
3. Mr Amare Tariku University of Gondar
   Tel: +251-918-724376: E-mail: _____

Annex 2- የመረጃና የስምምነት ውል ቅፅ /Information Sheet Amaharic version/

የጤና ኤክስቴንሽን ፕሮግራም የማህበረሰብ እርካታ እና ተያያዥ መንሴዎች በሎ ጅጋንፎይ ወረዳ ከማሽ ዞን ቤኒሻጉል ጉሙዝ ክልል መንግስት ምራዕብ ኢትዮጵያ

<u>የመረጃና የስምምነት ውል ቅፅ</u>

የጥናት ቡድን _____

የጎንደር ዩኒቨርሲቲ

የተቋሙ ስም: የጎንደር ዩኒቨርሲቲ

የድጋፍ ሰጪ ስም: ----

የዋና ተመራማሪው ስም: አሸብር አብሹ

የጤና ኤክስቴንሽን ፕሮግራም የማህበረሰብ እርካታ እና ተያያዥ መንሴዎች በሎ ጅጋንፎይ ወረዳ ከማሽ ዞን ቤኒሻጉል ጉሙዝ ክልል መንግስት ምራዕብ ኢትዮጵያ ለማጥናት ለማህበረሰቡ የተዘጋጀ የመረጃና የስምምነት ውል ቅፅ

መግቢያ: ይህ የመረጃና የስምምነት ውል ቅፅ የተዘጋጀው የጤና ኤክስቴንሽን ፕሮግራም የማህበረሰብ እርካታ እና ተያያዥ መንሴዎች በሎ ጅጋንፎይ ወረዳ ከማሽ ዞን ቤኒሻጉል ጉሙዝ ክልል መንግስት ምራዕብ ኢትዮጵያ ለማጥናት ሲሆን ይህን ምርምር ከየጎንደር ዩኒቨርሲቲ ጋር በመተባበር እየሰራው አገኛለው ስለሆነም በበሎ ጅጋንፎይ ወረዳ በጤና ኤክስቴንሽን ፕሮግራም ያሎትን የእርካታ መጠን ልምድ እና አመለካከት እጠይቆታለው.

የጥናት ፕሮጀክቱ የሚካሄድበት ምክንያት: ጥናቱ የሚካሄድበት ምክኒያት የጤና ኤክስቴንሽን ፕሮግራም የማህበረሰብ እርካታ እና ተያያዥ መንሴዎች በሎ ጅጋንፎይ ወረዳ ለማጥናት ሲሆን ቃለ መጠይቁም በበሎ ጅጋነፎይ ወረዳ ከሚኖሩ ማህበረሰብ ክፍሎች ጋር ይሆናል ሚሰጡንም ምላሽ መንግስት ለሚያደረገው የጠናው ዘርፍ እቅድ ዝግጀትና የማህበረሰቡን የእርካታ ደረጃ ለማሻሻል ለምናደረገው ርብርብ ይረዳናል፡፡

አተገባበር: የጤና ኤክስቴንሽን ፕሮግራም የማህበረሰብ እርካታ እና ተያያዥ መንሴዎች በሎ ጅጋንፎይ ወረዳ ጥናት ለማድረግ እርሶን የፕሮጀክቱ አንዱ አካል ለማደረግ የጋበዝኖት ሲሆን የመረጃና የስምምነት ውል ቅፅ ላይ በመፈረም መሰማመቶን የሚገልጹልን ከሆነ የጥናት ቡድኑ ጥያቄዎችን ይጠይቆታል ሚሰጡን መረጃ በሚሰጢር የሚያዝ መሆኑን በፊርማችን እናረጋግጣለን

ሊገጥም የሚችል ችግር/አለመመቸት: በዚህ ጠናት ላይ በመሳተፈዎ ጊዜውት መሰዋት የሚደርጉ ቢሆንም የጤና ኤክስቴንሽን ፕሮግራም የማህበረሰብ እርካታ እና ተያያዥ መንሴዎች በሎ ጅጋንፎይ ወረዳ ለመለየት እና የጤና ኤክስቴንሽን ፕሮግራም ለማሻሻል የበኩሎትን ድርሻ የተወጡ በመሆኑ ለማህበረሰቡ ከፍተኛ ጠቀሜታ ይሰጣል በተጨማሪም በዚህ ጠናት ላይ በመሳተፈዎ ምንም አደጋ አንደማይደረስቦት እናረጋግጣለን፡፡

ጥቅሞች: በዚህ ጠናት ላይ በመሳተፈዎ የጤና ኤክስቴንሽን ፕሮግራም የማህበረሰብ እርካታ እና ተያያዥ መንሴዎች በሎ ጅጋንፎይ ወረዳ ከማሽ ዞን ቤኒሻጉል ጉሙዝ ክልል መንግስት ምራዕብ ኢትዮጵያ ለምዳረገው ጥናት ከፍተኛ አተዋጽዎ የሚኖረው ሲሆን የማህበረሰቡን የእርካታ ደረጃ ጠቋሚ ሞሆኑን እና የማህበረሰቡን ጤና ደረጃ ለማሻሻል ይረዳል፡፡

ጥቅማጥቅም:. በዚህ ጠናት ላይ በመሳተፈዎ ማንኛውም ጥቅማጥቅም የማይሰጦት መሆኑን እንገልፃለን

ምስጢራዊነት: የሚሰጡን መረጃ በሚስጢር የመያዝ መሆኑን እና የእርሶ ብቻ የሆነ መለያ ቁጥር የሚሰጦት ሲሆን በመጠይቁ ላይ ሰሞት የማይፍር መሆኑን እንገልጻለን በተጨማሪም በመለያ ቁጥር የተሰበሰበው መረጃ በዋና ተመራማሪወ እጅ በሚሰጢር ይቀመጣል

ያለመሰታፍና መብት/ ማቋረጥ: በዚህ ጥናት ላይ ያለመሰታፍ ሙሉ መብት ያሎት ሲሆን በቀጣይ በሚያገኙት የጤና አገልግሎት ላይ ተጽኖ ማያሳርፍ ይሆናል በተጨማሪም ከቀረቡት ጠያቄዎች መመለስ የማይፈለጉትን ማለፍም ሆነ ጥናቱን ማቋረጥ ይችላሉ፡፡

ሊገኙዋቸዉ የሚችሉዋቸው ሰዎች: ማንኛውም ጥናቱን በተመለከተ ጥያቄ ካሎት ከታች ተዘረዘሩትን የቡድኑ አባላት በተቀመጠው አድራሻ ማነጋገር ይችላሉ.

የዋና ተመራማሪው ስም:

አሸብር አብሹየንንደር ዩኒቨርሲቲ ስልክ ቁጥር: +251-920-29-15-48: ኢሜል: hiasher12@gmail.com

ሱፐርቫዘር

1. ዶ/ር መዝገቡ ይታያል የንንደር ዩኒቨርሲቲ ስልክ ቁጥር+251-947-057683: ኢሜል:

   _____

2. አቶ አማረ ታሪኩ የንንደር ዩኒቨርሲቲ ስልክ ቁጥር Tel: +251-918-724376: ኢሜል:

   _____

Annex 3: Data Collection Format

Data Extraction Format

Greeting

Dear participants

My name is ----------. I am working with Mr. Asheber Abeshu who is doing a research as partial fulfillment for the requirement of master of public health in human resource management for health at Gondar University on community' satisfaction with HEP and its associated factors at Bellojyganfoy Woreda. You are chosen randomly to give information concerning Socio-demographic variables, exposure with health extension program, and perception on Competency of Health Extension worker, time spent for giving service, accessibility, way of communication, and interpersonal relationship, and community and associated factors of community satisfaction. All this information will be retrieved from community member of Bellojyganfoy Woreda. This information will be collected by data collectors working in Bellojyganfoy Woreda. If you have any question concerning your procedure you can contact using the below listed phone numbers. Any information that you give will be very important in preventing the problem, so please pay attention and take your time to complete the questionnaire; the questionnaire may take 20 minute and I assure you that any information you gave me will be confidential since the name is not written on any paper . Even the investigator does not know the data owner. The analysis will not be performed on individual level. So please respond to all the entire questionnaires

Contact Information

1. Asheber Abeshu (Principal Investigator) Tel: +251-920-29-15-48
2. Dr Mezgebu Yitayal (Advisor)Tel: +251-9 Tel: +251-947-057683
3. Ato Amare Tariku (Advisor) Tel: +251-918-724376

Annex 4 Consent form

I have read the information sheet and I understood the purpose and the expected benefit of the research of this study. I hereby need to assure with my signature that I have signed without any coercion & I have decided to participate voluntarily to take part my contribution to the study which will help in the health service by HEWs

Signature----------

Date----------

Data Collection Format

001 data collection date -----/-----/-------dd/mm/yy
002 data number ----------
003 data code ----------
004 name of kebele ----------
005 kebele code ----------
Session1: Socio-demographic characteristics of respondent in belojganfoy woreda 2016

s/n	Question	Response	skip
101	Age of the respondent?		
102	Sex of the respondent?	Male ☐ Female ☐	
103	Ethnicity of the respondent?	Gumuz ☐ Berta ☐ Oromo ☐ Amahara ☐ Tigre ☐ Other ☐	
104	Level of education of the respondent?	Not educated ☐ Grade 1-4 ☐ Grade 5-8 ☐ Grade 9-10/12 ☐ Graduated from colleges/universities ☐	
105	Responsibility in the household of the respondent?	Husband ☐ Wife ☐	
106	Family size of the respondent?		
107	Occupation of the respondent?	Housewife ☐ Private employee ☐ Government employee ☐ NGO ☐ Others ☐	
108	Marital status of the respondent?	Married ☐ ✓ Mono gamy ☐ ✓ Poly gamy ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐	
109	Marital status of your wife/husband?	Mono gamy ☐ Poly gamy ☐	
110	Religion of the respondent?	Muslim ☐ Orthodox ☐ Protestant ☐ Catholic ☐	

Session 2: Respondents' exposure and interactions with HEWs, in belojganfoy woreda 2016

s/n	Question	Respond	Skip
201	Are you recognized as model family?	Yes ☐ No ☐	
202	Have you ever visited HP during the last one year?	Yes ☐ No ☐	
203	How much was the frequency of visit during the last one year?	< three times ☐ = > four times ☐	
204	How long you will take to reach at HP on foot (in minutes)	1-30 ☐ 31-60 ☐ >61 ☐	
205	How do you rate the availability of HEWs on job at health post?	Always ☐ Occasional ☐ Rarely ☐	
206	Have you ever returned home due to HP being closed?	Yes ☐ No ☐	
207	Did HEWs visited your home during the last one year?	Yes ☐ No ☐	
208	How frequently do HEWs conduct outreach services?	Most of the time ☐ Sometimes/intermittent ☐ Never ☐	
209	Do all members of your family involve on HEP?	Yes ☐ No ☐	
210	Are two HEWs are adequate per kebele?	Yes ☐ No ☐	
211	Would you support the involvement of female workers in HEP?	Yes ☐ No ☐	
212	Is the service provided by HEWs are enough?	Yes ☐ No ☐	
213	Ever received health information from HEWs?	Yes ☐ No ☐	
214	State your exposure to different health issues?	Proper and safe excreta disposal syste ☐ Proper and safe solid and liquid waste management; ☐ Water supply safety measures; ☐ Food hygiene and safety measures; ☐ Healthy home environment; ☐ Arthropods and rodent control; ☐ Personal hygiene; ☐ HIV/AIDS prevention and control; ☐ TB prevention and control; ☐ Malaria prevention and control; ☐ First AID ☐	

		Maternal and child health; ☐ Family planning; ☐ Immunization; ☐ Adolescent reproductive health; ☐ Nutrition ☐	
215	Have you perceived that you had positive interpersonal relationship with HEWs?	Yes ☐ No ☐	
216	Do you Participated in planning and implementation of HEP?	Yes ☐ No ☐	
217	Do you prefer to receive health related information or advice from HEWs?	Yes ☐ No ☐	

Session 3: community perception **(**perceived competence/Q301-310 10item/, perceived time spent/Q311-312 2item/, perceived accessibility/Q313-317 5item/, perceived relationship/Q318-322 5item/, perceived way of communication/Q323-328 6item/) with health extension program in Belojganfoy Woreda 2016

s/n	Question	Respond	Skip
301	Consult for the health problem to my need?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
302	Do the HEWs provide referral services to health centers if there is health problem?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
303	Does the HEW follow based on the referral result?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
304	Have you feel good on health extension worker being female?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
305	Does the HEW give you a complete explanation about what she teaches?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
306	Do you think that HEW is attentive	Strongly agree ☐ ☐	

	and caring?	Agree Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
307	Was HEW knowledgeable/understand my health problem?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
308	Does the HEW skillful to diagnose community health problems?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
309	Does the HEW make discussions on the health problem?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
310	Service System delivered by HEWS is Simple and trouble free	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
311	Does the health extension worker spent time to give health information during home visit to your need?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
312	Does the time spent to give health information and examination of at health post fit your need?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
313	Does the health extension worker visit your home on regular bases?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
314	Does the health extension worker frequently conduct outreach services?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
315	Does the health post is open regular	Strongly agree ☐ ☐	

	bases?	Agree Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
316	Does the health extension worker available on job at health post regular bases?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
317	Outreach services by HEWs address all community	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
318	You prefer to receive health related information or advice from HEWs	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
319	Are they relevant and that have positive interpersonal relationship with HEWs?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
320	The health extension worker s are known HEWs in person by the community	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
321	Do you support the involvement of female workers in HEP?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
322	Do HEWs Participated you in planning and implementation of HEP based on your need?	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
323	The health extension worker explaining things clearly… (Fully answering questions, explaining clearly, giving adequate information; not being vague it's to my need.	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
324	The health extension worker gives respect, being friendly and warm to	Strongly agree ☐ Agree ☐ ☐	

	me and, is treating with respect.	Neither agree nor disagree Disagree ☐ Strongly disagree ☐	
325	The health extension workers are giving time for me to fully describe my illness in at health post.	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
326	Exploring and communicating my health problem and are helping me to improve my health by myself.	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
327	The health extension workers are discussing the options, involving me in decisions making.	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	
328	Maintain privacy appropriately before doing any Procedure	Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree ☐	

Session 4: Community Satisfaction with health extension program, in belojganfoy woreda 2016

s/n	Question	Respond	Skip
401	How would you rate the quality of services you received by HEWs?	Very satisfied ☐ satisfied ☐ neutral ☐ dissatisfied ☐ Quite dissatisfied ☐	
402	To what extent has the program met your needs?	Very satisfied satisfied ☐ neutral ☐ dissatisfied ☐ Quite dissatisfied ☐	
403	How satisfied are you with the amount of help you have received by HEWs?	Very satisfied satisfied ☐ neutral ☐ dissatisfied ☐ Quite dissatisfied ☐	
404	Have the services you received helped you deal more effectively with your problems?	Very satisfied satisfied ☐ neutral ☐ dissatisfied ☐	

		Quite dissatisfied	
405	In an overall, general sense, how satisfied are you with the service you have received by HEWs?	Very satisfied satisfied ☐ neutral ☐ dissatisfied ☐ Quite dissatisfied ☐	

Questionnaire filled and completed by
Name _____
Signature _____
Date_____

Approved by
Name _____
Signature _____
Date_____

Annex 4: Data Collection Format Amahric version

<u>የመረጃና መጠይቅ ቅፅ</u>

ሰላም፡እንደምን አሉ----------አባላለሁ፡፡በጎንደር ዩኒቨርሲቲ የህብረተሰብ ጤና ክፍል የጤና የሰው ሀብት አስተዳደር የሁለተኛ ድግሪያቸውን እየተከታተሉ ከሚገኙት ከአቶ አሸብር አብሹ ጋር እየሰራው እገኛለሁ፡፡እዚህ የተገኘውት የመመረቂያ ጥናት መረጃ ለመሰብሰብ ነው፡፡ የጥናቱ ስያሜ የጤና ኤክስቴንሽን ፕሮግራም የማህበረሰብ እርካታ እና ተያያዥ መንሴዎች በሎ ጅጋንፎይ ወረዳ ከማሽ ዞን ቤኒሻጉል ጉሙዝ ክልል መንግስት ምርዕብ ኢትዮጵያ ሲሆን የመረጃና መጠይቅ ቅፅ የተዘጋጀው የጤና ኤክስቴንሽን ፕሮግራም የማህበረሰብ እርካታ እና ተያያዥ መንሴዎችን በሎ ጅጋንፎይ ወረዳ ከማሽ ዞን ቤኒሻጉል ጉሙዝ ክልል መንግስት ምርዕብ ኢትዮጵያ ለማጥናት ሲሆን ይህን ምርምር ከየጎንደር ዩኒቨርሲቲ ጋር በመተባበር እየተሰራ ይገኛል ስለሆነም በበሎ ጅጋንፎይ ወረዳ በጤና ኤክስቴንሽን ፕሮግራም ያላሎትን የእርካታ መጠን ልምድ እና አመለካከት እጠይቆታለው.መጠይቁም የመሰረታዊ መረጃ የማህበረሰብ አመለካከት የጤና ኤክስቴንሽን ፕሮግራም ልምድና የእርካታ መጠን የሚዳስሱ ምረዓፍዎችን ያካትታል፡፡ መረጃውም በሎ ጅጋንፎይ ወረዳ በሚሰሩ ሰራተኞች የሚሰበሰብ ሲሆን መረጃዎቹም ከበሎ ጅጋንፎይ ወረዳ ነዋሪዎች የሚሰበሰቡ ይሆናል፡፡ስለመረጃዎቹ ማንኛውም ጥያቅ ካሎት ከታች በተዘረዘሩት ስለክ ቁጥሮች መጠየቅ ይችላሉ፡፡ ስለሆነም የሚሰጡን መረጃ ጠቀሜታው ላቅ ያለ መሆኑን ተገንዘበው ግዜ ወስደው ጥቄዎቹን እነዲመልሱ በትህትና እንጠይቃለን፡፡ በመጨረሻም የሚሰጡን መረጃ ሚስጥራዊነቱ የተጠበቀ መሆኑን እናረጋግጣለን፡፡

ሊገናኙዋቸዉ የሚችሉዋቸው ሰዎች

1. አሸብር አብሹ የጎንደር ዩኒቨርሲቲ
   ስልክ ቁጥር: +251-920-29-15-48: ኢሜል: *hiasher12@gmail.com*

ሱፐርቫዘር

1. ዶ/ር መዝገቡ ይታያል የጎንደር ዩኒቨርሲቲ
   ስልክ ቁጥር+251-947-057683: ኢሜል: _____
2. አቶ አማረ ታሪኩ
   ስልክ ቁጥር Tel: +251-918-724376: ኢሜል: _____

Annex 5: Consent form Amahric version

<u>የስምምነት መስጫ ቅፅ</u>

እኔ ከዚህ በታች የፈረምኩት ስለጥናቱ ዓላማና ጥቅም ተረዴቸና አስፈላጊ መሆኑን አምኝበት በጥናቱ ላይ ለመሳተፍ ያለምንም ተፅዕኖ በራሴ ፈቃድ ተሳታፊ መሆኔን አረጋግጣለሁ፡፡

ፊርማ_____

ቀን _____

<u>የመረጃና መጠይቅ ቅፅ</u>

001 የመረጃ መሰብሰቢያ ቀን ----------ቀን/ወር/ዓ.ም

002 የመጠይቁ ቁጥር ----------

003 የጠያቂው ኮድ ----------

004 የቀበሌው ስም ----------

005 የቀበሌው ኮድ ----------

ክፍል1: የመላሾችን መሠረታዊ መረጃ በሎ ጅጋነፎይ ወረዳ 2016

ተ.ቁ	ጥያቄ	መልስ	ወደ
101	እድሜዎ ስንት ነው?		
102	ፆታ	ወንድ ☐ ሴት ☐	
103	ብሄሮት ምንድን ነው?	ጉሙዝ ☐ በርታ ☐ ኦሮሞ ☐ አማራ ☐ ትግሬ ☐ ሌላ ☐	
104	የት/ት ደረጃዎ ምንድን ነው?	ያለተማረ ☐ 1-4 ክፍል ☐ 5-8 ክፍል ☐ 9-10/12 ክፍል ☐ ከኮሌጅ/ዩኒቨርስቲ የተመረቀ ☐	
105	በቤተሰቡ ያሎት ሀላፊነት ምንድን ነው?	ባል ☐ ሚስት ☐ ሌላ ☐	
106	የቤተሰብዎት ብዛት ስንት ነው?		
107	ስራዎት ምንድን ነው?	የቤት እመቤት ☐ በግል ስራ የተሰማራ ☐ የመንግስት ሰራተኛ ☐ መንግሰታዊ ያልሆኑ ተቋማት ሰራተኛ ☐ አርሶ አደር ☐ ሌላ ☐	
108	የትዳር ሁኔታዎ እንዴት ነው?	ያገባ ☐ ✓ አንድ ብቻ ያገባ ☐ ✓ ከአንድ በላይ ያገባ ☐ ያለገባ ☐ ባል/ሚስት የሞተባት ☐ የተፈታ ☐	
109	የባለቤቶ የትዳር ሁኔታዎ እንዴት ነው?	አንድ ብቻ ያገባ ☐ ከአንድ በላይ ያገባ ☐	

110	ሀይማኖትዎ ምንድን ነው?	ኦርቶዶክስ ክርስትያን ☐ እስልምና ☐ ፕሮቴስታንት ☐ ካቶሊክ ☐	

ክፍል 2: የማህበረሰቡ የጤና ኤክስቴንሽን ፕሮግራም ልምድና ከጤና ኤክስቴነሽን ሠራተኞች ጋር ያላቸው ግኑኝነት በሎ ጅጋነፎይ ወረዳ 2016

ተ.ቁ	ጥያቄ	መልስ	ወደ
201	ሞዴል አናወራ/እማወራ ሆነው ተመርቀዋል;	አዎ ☐ የለም ☐	
202	ባለፈው አንድ አመት ውስጥ ጤና ኬላ ጎብኝተው ያውቃሉ?	አዎ ☐ የለም ☐	
203	ባለፈው አንድ ለምን ያህል ጊዜ ጉብኝት አድረገዋል?	< 3ግዜ ☐ = > 4ግዜ ☐	
204	ጤና ኬላ ለመድረስ ከቤቶ በደቂቃ ምን ያህል ያስኬዶታል?	1-30 ☐ 31-60 ☐ >61 ☐	
205	የጤና ኤክስቴንሽን ባለሙያዎች ጉብኝት እና በስራ ላይ መገኘታቸውን እንዴት ይመዝኑታል?	ሁል ግዜ ☐ አልፎ አልፎ ☐ ጥቂት ግዜ ☐	
206	ጤና ኬላ ተዘግቶ ወደ ቤቶ ተመልሰው ያውቃሉ?	አዎ ☐ የለም ☐	
207	ባለፈው አንድ አመት ውስጥ በጤና ኤክስቴንሽን ባለሙያውች የቤት ለቤት ጉብኝት ተደርጎሎታል?	አዎ ☐ የለም ☐	
208	ለምን ያህል ጊዜ በጤና ኤክስቴንሽን የቤት ለቤት ጉብኝት አድረገዎሎታል?	ሁል ግዜ ☐ አልፎ አልፎ ☐ ጥቂት ግዜ ☐	
209	በጤና ኤክስቴንሽን ፕሮግራም ሁሉም የቤተሰቡ አባላት ተሳታፊ ናቸው?	አዎ ☐ የለም ☐	
210	ሁለት ጤና ኤክስቴንሽን ሰራተኞች ለቀበሌው በቂ ናች ይላሉ?	አዎ ☐ የለም ☐	
211	ጤና ኤክስቴንሽን ሠራተኞች ሴቶች መሆናቸውን ይደግፋሉ?	አዎ ☐ የለም ☐	
212	በጤና ኤክስቴንሽን ሠራተኞች የሚሰጠው አገልግሎት በቂ ነው ይላሉ?	አዎ ☐ የለም ☐	
213	በጤና ኤክስቴንሽን ባለሙያዎች የጤና መረጃ አገልግሎት ተሰጠዎት ያውቃሉ?	አዎ ☐ የለም ☐	
214	መልስዎ አዎ ከሆነምን ምን አገልግሎት አግኝተው ያውቃሉ?	የመፀዳጃ ቤት ንፅህና አያያዝ ፓኬጅ ☐ የደረቅና ፍሳሽ ቆሻሻ አወጋገድ ፓኬጅ; ☐ የወታ ንፅህናና አያያዝ ፓኬጅ ☐ የምግብ ንፅህናና ፓኬጅ ☐ የቤት ንፅህናና አያያዝ ፓኬጅ ☐ ነፍሳት ቁጥጥር ፓኬጅ ☐ የግሌ ንፅህና ፓኬጅ ☐ በHIV/AIDS ፣(በግብረ-ስጋ ግኑኝነት የሚመጡ በሽታዎችን መከሊከሌና መቆጣጠር) ፓኬጅ ☐ ቲቢ መከላከልና መቆጣጠር ፓኬጅ; ☐ ወባ መከላከልና መቆጣጠር ፓኬጅ; ☐ የመጀመሪያ ህክምና እርዳታ አሰጣጥ ፓኬጅ ☐ የእናቶችና ህፃናት ጤና ፓኬጅ ☐ በተሴብ ምጣኔ ፓኬጅ ☐ በክትባት ፓኬጅ ☐ በወጣቶች ስነ-ተዋሌዶ ጤና ፓኬጅ ☐ በስነ-ምግብ ፓኬጅ ☐	

215	በጤና ኤክስቴንሽን ባለሙያዎች ጋር መልካም ግኑኝነት አለኝ ብለው ያምናሉ?	አዎ ☐ የለም ☐	
216	በጤና ኤክስቴንሽን ፕሮግራም እቅድ ዝግጅት እና ትግበራ ተሳትፈው ያውቃሉ?	አዎ ☐ የለም ☐	
217	በጤና ኤክስቴንሽን ባለሙያዎች የጤና መረጃና የምክር አገልግሎት ቢሰጠዎት ነቅድሚያነት ይመርጣሉ?	አዎ ☐ የለም ☐	

ክፍል 3: የማህረሰቡን በጤና ኤክስቴንሽን ባለሙያዎች በሚሰጠው አገልግሎት ላይ ያላቸውን ግንዛቤ እና አመለካከት የሚዳስሱ መጠይቆች:: በሎ ጅጋንፎይ ወረዳ2016

ተ.ቁ	ጥያቄ	መልስ	ወደ
301	የጤና ኤክስቴንሽን ባለሙያዎች የማማከር አገልግሎት ፍላጎቶዎን አሟልቶዋል?	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
302	አስፈላጊ ሆኖ ሲገኝ ለከፍተኛ ምርመራ ወደ ሚመለከተው የጤና ባለሙያ የመላክ ልምድን እንዴት ይመዙኑታል?	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
303	የጤና ኤክስቴንሽን ባለሙያዎች ለከፍተኛ ምርመራ ወደ ሚመለከተው የጤና ባለሙያ የተላኩት በተሰጠው ግብረ መልስ መሰረት በሽተኛን የመከታተልን ልምድን እንዴት ይመዙኑታል?	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
304	የጤና ኤክስቴንሽን ባለሙያዎች ሴቶች በመሆናቸው መልካም ስሜት አለዎት?	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
305	የጤና ኤክስቴንሽን ባለሙያዎች ሙሉ ማብሪያሪያ በሰጡት ት/ት ላ ይሰጣሉ?	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
306	የጤና ኤክስቴንሽን ባለሙያዎች አዳማጭ እና ተንከባካቢ ናቸው	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
307	የጤና ኤክስቴንሽን ባለሙያዎች እቀት ያላቸው እና የጤና ችግሮትን ይረዳሉ?	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
308	የጤና ኤክስቴንሽን ባለሙያዎች የማህበረሰቡን የቴና ችግር የመፍታት ክህሎት አላቸው?	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
309	የጤና ኤክስቴንሽን ባለሙያዎች ማህበረሰቡን በጤና ችግሮችን ያወያሉ	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
310	በጤና ኤክስቴንሽን ባለሙያዎች የሚሰጠው ነፃ ቀላል እና	አጥብቄ እስማማለው ☐	

	ከችግሮች ነፃ ነው	እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
311	የጤና ኤክስቴንሽን ባለሙያዎች በቤት ለቤት ጉብኝት ወቅት ተገቢውን ግዜ የጤና መረጃን ለመስጥ ይጠቀማሉ	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
312	የጤና ኤክስቴንሽን ባለሙያዎች ጤና ኬላ ተገቢውን ግዜ የጤና መረጃን ና ህክምና ለመስጥ ይጠቀማሉ	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
313	የጤና ኤክስቴንሽን ባለሙያዎች ቤቶን በመደበኛ የግዜ ሰሌዳ ይጎበኛሉ	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
314	የጤና ኤክስቴንሽን ባለሙያዎች በመደበኛ የግዜ ሰሌዳ የደርሶ መልስ አገልግሎቶችን ይሰጣሉ	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
315	ጤና ኬላ በመደበኛ የግዜ ሰሌዳ ክፍት ነው	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
316	የጤና ኤክስቴንሽን ባለሙያዎች ጤና ኬላ በመደበኛ የግዜ ሰሌዳ ይገኛሉ	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
317	የጤና ኤክስቴንሽን ባለሙያዎች በደርሶ መልስ ፕሮገራም ለምሳሌ ክትባትአገልግሎትን ለሁሉም የማህበረሰብ ክል ያደርሳሉ	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
318	በጤና ኤክስቴንሽን ባለሙያዎች የጤና መረጃና የምክር አገልግሎት ቢሰጠዎት ነቅድሚያነት ይመርጣሉ?	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
319	የጤና ኤክስቴንሽን ባለሙያዎች ጠቃሚና መልካም ጉኑኝነት አላቸው.	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
320	የጤና ኤክስቴንሽን ባለሙያዎች በማህበረሰቡ የታወቁ ናቸው	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
321	የጤና ኤክስቴንሽን ባለሙያዎች ሴቶች መሆናቸውን ያበረታታሉ	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐	

		አልሰማም አጥብቄ አልሰማም ☐	
322	የጤና ኤክስቴንሽን ባለሙያዎች በፕሮግራሙ እቅድ ዝግጅት እና አተገባበር ላይ በሚፈልጉት መልኩ ያስተፎዎታል	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
323	የጤና ኤክስቴንሽን ባለሙያዎች ነገሮችን በግልጽ ያብራራሉ ጠያቄዎት በተገቢው መልኩ ይመልሳሉ በቂ መረጃ በፈለጉት መልኩ ይሰጣሉ	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
324	የጤና ኤክስቴንሽን ባለሙያዎች ተገቢውን አክብሮት ይሰጣል ምልካም ተግባቦት አላቸውና በመልካም ሁኔታ አገልግሎት ይሰጦዎታል	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
325	የጤና ኤክስቴንሽን ባለሙያዎች ተገቢዉን ግዜ የጤና ችግሮቼን እንድናገር ይሰጦዎታል	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
326	የጤና ኤክስቴንሽን ባለሙያዎች በመፈተሽ አስፈላጊው ውይይት በማድረግ የጤና ችግሮቼን በራሴ እንደፈታ ይረዱኛል.	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
327	የጤና ኤክስቴንሽን ባለሙያዎች የመፍቴ አማራጮችን በመስጠት ለውሳኔ ሰጪነት ያበቁኛል	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	
328	የጤና ኤክስቴንሽን ባለሙያዎች ይእርሶን አስፈላጊ ግላዊ ፍላጎቶትን በማንኛውም አገልግሎት አሰጣጥ ወቅት ይጠቢቃሉ	አጥብቄ እስማማለው ☐ እስማማለው ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አልሰማም ☐ አጥብቄ አልሰማም ☐	

ክፍል 4: የማህረሰቡን በጤና ኤክስቴንሽን ባለሙያዎች በሚሰጠው አገልግሎት ላይ ያላቸውን እርካታን የሚዳስሱ መጠይቆች:: በሎ ጅጋንፎይ ወረዳ2016

ተ.ቁ	ጥያቄ	መልስ	ወደ
401	ከጤና ኤክስንቴንሽን ባለሙያዎች ያገኙት አገልግሎት ምን ያክል ጥራት አለው ይላሉ ?	በጣም ያረካል ☐ ያረካል ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አያረካም ☐ በጣም አያረካም ☐	
402	ከጤና ኤክስንቴንሽን ባለሙያዎች የሚሰጠው አገልግሎት በምን ያክል መጠን ፍላጉቴን አሙልቷል ይላሉ?	በጣም ያረካል ☐ ያረካል ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አያረካም ☐ በጣም አያረካም ☐	
403	ከጤና ኤክስንቴንሽን ባለሙያዎች በሚፈልጉት መልኩ እርዳታ አግኝቻለው ይላሉ?	በጣም ያረካል ☐ ያረካል ☐ ገለልተኛ/ሃሳብ አልሰጥም/ ☐ አያረካም ☐ በጣም አያረካም ☐	
404	በጤና ኤክስንቴንሽን ባለሙያ የተሰጠኝ እርዳታ ከጤናየ ችግር	በጣም ያረካል ☐	

	አንፃር ያገኙት ርዳታ በምን ያክል መጠን ረድቶኛል ብለው ያምናሉ?	ያረካል ገለልተኛ/ሃሳብ አልሰጥም/ አያረካም በጣም አያረካም	☐ ☐ ☐ ☐	
405	በአጠቃላ በጤና ኤክስቴንሽን ባለሙያዋ ያገኙት አገልግሎት አርክቶዎታል? የርካታዎን መጠን ይግለጹ	በጣም ያረካል ያረካል ገለልተኛ/ሃሳብ አልሰጥም/ አያረካም በጣም አያረካም	☐ ☐ ☐ ☐ ☐	

መረጃውን የሞላው **ያረጋገጠው**

ስም _____ **ስም** _____

ፍርማ _____ **ፊርማ** _____

ቀን_____ **ቀን**_____

ሰላደረጉልኝ ትብብር በጣም አመሰግናለሁ!

Annex 6: Focus Group Discussion Guide Line

Hello dear participants I am Asheber Abeshu MPH student in university of Gondar. A study is being carried out by university of Gondar on community' satisfaction with HEP and its associated factors at Bellojyganfoy Woreda and for that matter I am the investigator. The discussion among you will help us to identify key areas of intervention to asses level of satisfaction and associated factors with HEP. Therefore you are kindly request to actively participate in the discussion. Your role in the success of the research is important and I appreciate your contribution to the research. Would this is okay with you.

In the process after we conduct some brief introduction to each other we will discuss on a certain list of topics. We will discuss on each issues in detail on level of satisfaction. I will give you a chance for all of you to talk on each topic and my friend _____ will use tape recorder in order not to miss what you say. During the discussion no wrong idea, every points you have are very important for the study. Everything we discussed here is confidential. Nobody other than me and my friend can access the recordes and notes we take. The discussion have both contextual and evaluative questions then we will conclude the session by asking you for your recommendations on how to increase on level of satisfaction of the community with HEP. Would you be willing to participate in the discussion? If yes proceed, if no thank and stop the discussion. Do you have any concern before we start?

I understood about the advantage of the research the role I will have in the research. I have agreed to participate in the research.

Yes ☐ No ☐

Name of the moderator-: _____ sign: _____

(Signature of the moderator certifies the concent has been obtaind verbally)

Date _____ time_____

Discussion points

1. What are the factors that discourage the community to use the health extension program?
2. What are the strengths and weaknesses of the health extension workers in relation to their competence?
3. How you state the accessibility of the health extension workers on health post and on home visit how is the time they spent to deliver the health service?
4. What do you say about the way of communication of health extension workers the relationship that they have with the community?
5. Do you have suggestions on what can be done to enhance the level of satisfaction of the community with health extension program?

Annex 7: የቡድን ውይይት መከወኛ መመሪያ/Amaharic FGD Guide Line/

ሰላም ጤና ይስጥልኝ ውድ ተሳታፊዎች አቶ አሸብር አብሹ እባላለሁ፡፡በጎንደር ዩኒቨርሲቲ የህብረተሰብ ጤና ክፍል የጤና የሰው ሀብት አስተዳደር የሁለተኛ ድግሪዬን እየተከታተልኩ እገኛለው ::. የጥናቱ ስያሜ የጤና ኤክስቴንሽን ፕሮግራም የማህበረሰብ እርካታ እና ተያያዥ መንሴዎች በሎ ጅጋንፎይ ወረዳ ከማሽ ዞን ቤኒሻጉል ጉሙዝ ክልል መንግስት ምርዕብ ኢትዮጵያ ሲሆን እኔ ዋና ተመራማረው መሆኔን እገልፃለው፡፡ ከእናንተ ጋር የሚደረገው ውይይት የጤና ኤክስቴንሽን ፕሮገራመ የማህረሰቡን የእርካታ መጠንን የሚጠቁም እና ተየያዥ መንሴዎችን ለመለየት የሚረዳን ይሆናል፡፡ ስለሆነም በውይይቱ የነቃ ተሳትፎ እንድታደረጉ እየጋበዝኩ ተሳትፎዎት በቀጣይ ለፕሮገራሙ መሻሻል ጉልህ ድርሻ ነኖረዋል፡፡. በውይይት ሂደቱ ላይ አጭር የመግቢያ ዳሰሳ የሚኖረን ሲሆን ከታች በተዘረዘሩት ነጥቦች ላይ ሰፋ ያለ ዳሰሳ እናደርጋለን፡፡ ለሁሉም ተሳታፊዎች የመናገር እድል የምንሰጥ ሲሆን ጓደኛዬ አቶ/ወ/ሮ/ሪት_____ ቴፕ ድምፅ መቅረጽ በመጠቀም ሃሳባቹን የምትቀርጽ/የሚቀርጽ ስሆን ማስታወሻ በምይዝበት ወቅት ሃሳባቹ እንዳይሸራረፍብን ይረዳናል፡፡ በዚህ ወይይት ስተት ነው የሚባል ሃሳብ የሌለ ሲሆን የሚሰጡን ማንኛውም መረጃ ፋይዳው የላቀ መሆኑን መግለፅ አወዳለው በተጨማሪም የሚሰጡት ሃሳብ/መረጃ ሚስጢራዊነቱ የተጠበቀ መሆኑን አረጋግጣለው፡፡በመጨረሻም ጥያቄዎቹ ከፕሮገራሙ መነሻነትና መዛኝ የሆኑ ክፍሎች አሉት በዚህ መሰረት ለሁሉም ተሳታፊ በፕሮገራሙ ላይ ያለው የማህበረሰብ እርካታ ለመጨመር ምን መደረግ እንዳለበት የመፍትሄ ሃሳብ እንድታመነጩ እድሉን እሰጣለው፡፡.ለውይይቱ ዝጁ ናቹሁ? ውይይቱ በነጻነት የሚካሄድ ስለሆነ ማንኛው ውይይቱ ላይ ለመሳተፍ ፍላጎት የሌለው ሰው ያለመሳተፍ መብቱ የተጠበቀ ነው፡፡ ወደ ውይይቱ ከመግባታችን በፊት ያሳሰባችሁ ነገር ካለ ማንሳት ይቻላል፡፡

ከዚህ በታች የፈረምኩት ስለጥናቱ ዓላማና ጥቅም ተረዴቸና አስፈላጊ መሆኑን አምኝበት በጥናቱ ላይ ለመሳተፍ ያለምንም ተፅዕኖ በራሴ ፈቃድ ተሳታፊ መሆኔን አረጋግጣለሁ፡፡.

እስማመለው ☐ አለልስማማም ☐

የአወያዩ ስም-: _____ ፊርማ: _____

(የአወያዩ ፊርማ በቃል ለተገቡ ውሎች ማረጋገጫ ይሆናል)

ቀን _____ ሰዓት_____

መወያያ ነጥቦች

1. ማህበረሰቡ የጤና ኤክስቴንሽፕሮገራምን እንዳይጠቀሙ የሚደረጉ መንሴዎች ምንድን ናቸው?
2. ካላቸው ብቃት ጋር በተያያዘ የጤና ኤክስቴንሽን ባለሙያዎች ያላችው ጠንካራ እና ደካማ ጎኖች ምንድንናቸው ?
3. የጤና ኤክስቴንሽን ባለሙያዎች በጤና ኬላ የመገኘት አገልግሎቱ ለመስጠት የሚሰጡት ግዜ እነዴት ይይገልጹታ?ገልጹታ?
4. የጤና ኤክስቴንሽን ባለሙያዎች ያላቸውን ተግባቦት እና ከማህበረሰቡ ጋር ያላቸውን ግኙኝነት እንዴት ይገልጹታ?
5. በመጨረሻም በፕሮግራሙ ላይ የማህበረሰብ እርካታ ለመጨመር ምን መደረግ አለበት ይላሉ?

Annex 8: Data Quality Control Assessment Protocol

Duties of the data collector

1. The data collector should be respectful of the social culture of the community
2. Data collector should attain discussion session at the end each data collection data at11:30 am local time
3. The data collector have the responsibility to check the completeness of the questioners
4. The data collector is responsible for the confidentiality the information he/she collects
5. Forcing respond ants without the willingness is not allowed
6. All other stated rules of which have relation with data will be applicable and the data collector have duties to respect
7. Finally the data collector will sign the agreement

Duties of the investigator

1. He has the responsibility to cascade the discussion session
2. He has the duty to timely pay for data collectors
3. Other related rules to agreement are respected
4. Finally the investigator will sign the agreement

Name of data collector---------- Name of investigator----------

Sign---------- Sign----------

Date---------- Date----------

Eye wetness

1. Name----------sign----------date----------
2. Name----------sign----------date----------
3. Name----------sign----------date----------

Discussion session

Hello dear data collectors good evening this is the regular meeting after data collection of the day. I would like if u all check for the completeness of the questioners and then we will discuss on the performance of the day.

1. What were our strengths of the day?
2. What was our weakness of the day?
3. What was our opportunity we found of the day?
4. What were our treats we found of the day?
5. Please suggest the way forward of our task?

Declaration

I, the undersigned, senior MPH student declare that this proposal is my original work in partial fulfillment of the requirement for the degree of Master of Public Health in human resource management for health.

Name: Asheber Abeshu

Signature: _____

Place of submission: Institute of public Health, College of Medicine and Health Sciences, University of Gondar.

Date of Submission: _____

This proposal thesis has been submitted with my/ our approval as university advisor(s).

Advisors

Name	Signature
Dr Mezgebu Yitayal (PHD)	_____
Mr Amare Tariku (MSc, BSc)	_____

ASSURANCE OF INVESTIGATOR

I, the undersigned, senior MPH student agree to accept responsibility for the scientific, ethical and technical conduct of the research project and for provision of required progress reports as pre terms and conditions of the research and publications office of the University of Gondar.

Name of the student: _____

Date: _____ Signature: _____

Approval of the advisor (s)

Advisors

	Name	Signature	Date
1.	Dr Mezgebu Yitayal (PHD)	_____	_____
2.	Mr Amare Tariku (MSc, BSc)	_____	_____